mobilization
physical therapy

CONSENT FOR CARE

Thank you for choosing Mobilization Physical Therapy as your physical therapy, health and wellness provider. By signing this form you are giving consent for Mobilization and Physical Therapy to provide the desired services as requested by either yourself or your family member.

By signing this form you are attesting to the following:

1. I, the undersigned, have given full disclosure of any and all relevant past medical history that may impact, influence or contraindicate the prescribed services provided by Mobilization Physical Therapy.

2. I do hereby agree and give my consent to receive physical therapy or wellness services, which are deemed medically necessary as dictated by prudent medical practices by my illness, injury or condition and provided by authorized personnel of Mobilization Physical Therapy.

3. I understand that Mobilization Physical Therapy is fully licensed and insured and its providing therapists are licensed, highly trained and skilled. These therapists will ensure that the service they provide is safe, appropriate and indicated.

4. While Mobilization Physical Therapy fully intends to give service that offers no harm, I understand that there is always the potential for an unforeseen accident to occur. Should this be the case, I recognize that Mobilization Physical Therapy has taken every necessary precaution to protect me, and therefore, I DO NOT HOLD Mobilization Physical Therapy liable for any unforeseen injury.

Signature of Patient	Printed Name	Date
Signature of Legal Guardian	Printed Name	Date

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FINANCIAL & CANCELLATION POLICY

This is an agreement between Mobilization Physical Therapy, LLC as creditor, and the patient/debtor named on this form. By signing below, you are executing this agreement and attest to the following:

1. Mobilization Physical Therapy is a private, cash pay company, and is not contracted with any insurance companies, including Medicare. Mobilization Physical Therapy will not submit insurance claims for me.

    - **FOR NON-MEDICARE INSURED PATIENTS**: At my request, Mobilization Physical Therapy will provide me with an invoice ("superbill") for me to file a claim on my own to my insurance company. Mobilization will not file claims on my behalf. I am responsible for determining if a physician referral is required for claim reimbursement prior to my first appointment.

    - **FOR MEDICARE PATIENTS:** In signing this Financial Responsibility form, I am choosing to opt-out of my Medicare benefits, including submission to Medicare for potential reimbursement. Federal regulations require that a Medicare eligible patient acknowledge and sign such a waiver when choosing to engage in private-pay services.

2. I (the patient/debtor) am agreeing to pay for all services that are received. Mobilization accepts credit/debit cards, cash, check and FSA/HSA cards. Unless other arrangements are approved in writing, I understand that payment for services is due at the time of service and is past due if not paid by the subsequent treatment session. I understand that I will need to pay all past due amounts before receiving subsequent treatment intervention. Failure to pay account in-full within 90 days of date of service will result in turning account over to a collection agency.

3. When canceling a scheduled appointment, Mobilization requires notification to our office by phone or email 24 business hours prior to the scheduled appointment time. If you do not cancel and do not show up for your appointment, a NO-SHOW FEE of $25.00 will be charged.

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force, effective as of date signed.

_____	_____	_____
Signature of Patient/Debtor	Printed Name	Date

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ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY POLICY

Our HIPAA Notice of Privacy Policy can be viewed and printed (if desired) on our website, mobilizationpt.com. By signing below, I acknowledge that I have been informed of and given the right to review and secure a copy of Mobilization Physical Therapy's Notice of Privacy Policy.

_____ _____

Signature of Patient (or Legal Guardian) Date

CONSENT FOR EMAIL & TEXT COMMUNICATIONS

I, the undersigned, give permission to the practitioner/s of Mobilization Physical Therapy to communicate with me via email and/or text. I understand that Mobilization takes measures to protect my privacy, but cannot guarantee the security of Protected Health Information (PHI) via email or text.

- ☐ Yes, I give consent to use email or text for Office Communications (appointment reminders, communication with PT/staff only).
- ☐ No, I do not give consent to use email or text for any purpose.

_____ _____

Signature of Patient (or Legal Guardian) Date